



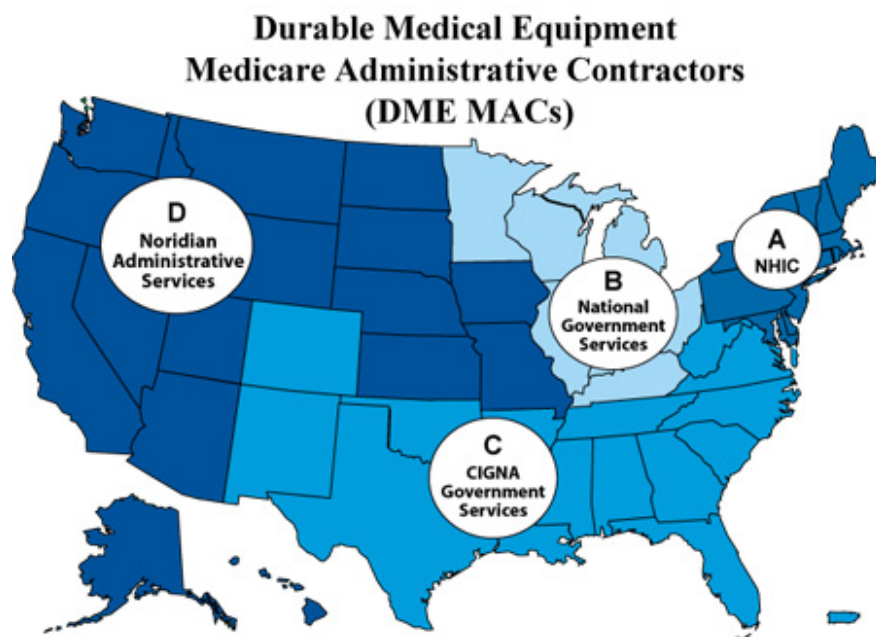
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Background

In 2010, Medicare providers or Home Medical Equipment Dealers (sometimes referred to as HME'S or DME'S, Durable Medical Equipment Dealers) processed over 75,000,000 Medicare part B claims for Home Medical Equipment through the Medicare System. Medicare is split into 4 regions and is administered based on 5 year contracts by private insurance companies. These regions are A, B, C, and D. Each region has a geographic coverage area that is split up by adjoining states. Below is a map indicating the current coverage areas.



Medicare Part B items can be among the most difficult of all items to prescribe by physicians. Unlike prescribing prescription medications, Medical equipment often cannot be simply prescribed by the treating physician and then reimbursed. In many cases the patient may be required to “qualify” through some sort of testing or evaluation and documentation process in order to meet the requirements for Medicare payment for equipment. Due to this stringent process on many types of equipment as well as all of the required coverage criteria and supporting documentation that must be completed, prescribing home medical equipment can be a very tedious process for both physicians and home medical equipment providers. Under today’s system, it can take an HME between 9 and 27 days to complete all of the required paperwork, testing, qualifying, documentation and other requirements to ensure reimbursement by Medicare. As more complicated treatments are developed, this process continues to get worse and more cumbersome for HME providers.

In 2010 Medicare reimbursed approximately \$10.5 Billion dollars for claims submitted to the Medicare system for home medical equipment. It is important to understand that Medicare's reimbursement is still based on the Honor system. What this means is that during the billing process, HME providers bill Medicare using a HCPCS coding that identifies products and services rendered to Medicare Beneficiaries. If a product that has been prescribed by a Physician requires a "qualification" and or additional documentation to support the medical necessity, then two letters alphabetic "Modifiers" are placed onto the end of the HCPCS codes. These alpha characters represent to Medicare that the HME provider has, in fact, completed the required "qualification" and/or has the supporting documentation required by Medicare in their possession. It is important to note that at no time is this required information submitted to Medicare. The Modifier is an indicator to Medicare that, should Medicare decide to review these required documents, the provider has them and can provide Medicare with these documents.

In 2010, Medicare processed over 75,000,000 total Medicare Claims for home medical equipment. Based on the Office Inspector General (OIG) report for 2010, the OIG believes that 50.9% of those claims did not meet the coverage requirements or possess the required documentation. This means that Medicare improperly paid over \$5 billion in claims for Home Medical Equipment. To fully understand this, it is important to understand exactly what may have been deemed as Fraud. Fraud can take multiple forms in Medicare. Fraud can be that an HME provider never supplied an item, yet they billed Medicare for this item. Fraud can be that an item was delivered to a patient yet all of the required documentation or qualification was not present. Fraud can also be that the item was delivered and documentation or qualification was present but the criteria required for that item was not met by the patient.

There are several reasons that improper payments account for over 50% of the Medicare Part B home medical equipment expenditures. The first and primary reason is that since Medicare uses the Honor system mentioned above, the only way to catch Fraud is through physical audits of providers. This is obviously a very long and tedious process and impossible to catch the majority of fraudulent claims. In 2010 over 100,000 Medicare Part B providers in the U.S billed Medicare for home medical equipment. It is unknown exactly how many Medicare auditors there are in the U.S., but it is very safe to assume that there is no way that they can cover this huge number of providers. When fraud is found, Medicare seeks to recoup damages based on the type of fraud created and can be, in some cases, triple the amount actually paid to the provider by Medicare. In most cases, the HME providers do not have the money to pay the fines so much of the overpayments due to fraud are never collected. For all fraud detected, investigated, and prosecuted, Medicare still only recoups less than 50% of the money paid out on average. The second reason that Fraud accounts for such a high proportion of

Medicare spending is the complicated process of billing and documenting the patient requirements that are mandated by Medicare. It has been reported that Medicare changes the rules once every 15 minutes for some item reimbursed by Medicare. Providers receive mounds of complicated to read paperwork from Medicare and the regional DME MACS, (The Private Insurance company administering Medicare benefits in the area that the patient resides) each month. In most cases, providers do their best to interpret these requirements but spend a tremendous amount of money on consultants and attorneys to ensure that their processes and procedures for patient processing and billing are accurate. In many cases, even when the DME MAC is contacted directly and asked specific questions, they may be unable to provide a correct answer. It is also well documented that if an HME provider were to call two different customer service representatives for any of the DME MAC insurance providers, they are likely to get two different and possibly conflicting responses to their questions.

Approximately 15.5% of all claims submitted to Medicare are denied. There can be multiple reasons for why a claim can be denied, but in most cases, the reason for denial is that the claim filed was not completed correctly. Denied claims cost the regional insurance companies approximately 15-25% more to process. Adding the denied claims to the reported fraud claims equals 65% of all claims possess some type of problem.

During January of 2009, President Obama launched an initiative that all healthcare records are to be electronic within the next 5 years. Unfortunately, most physicians and HME providers answer to that initiative has been to scan documents to files on computers and thus replace the paper files with electronic files. While this is successful in creating more office space, it is not providing a solution to the ongoing problem of fraud and provides no ability to report or analyze the data that is contained in those records.

Dream Software

Dream Software was founded in April 2009 with the concept that the future of Home Medical Equipment providers and Medicare would heavily depend on the use of Healthcare IT that would allow HME providers the ability to increase their sales and revenue without increasing their overhead. As Reimbursement for various Medical Equipment products continue to decrease and operating costs increase, it is imperative that HME providers fully embrace technology as a way to reduce overhead and increase efficiencies. It is well documented that each claim costs the average HME provider in excess of \$15.80 to only process the paperwork associated with the claim. This figure does not include the cost to deliver setup and maintain this patient nor does it include any allowance for customer service to answer questions for Physicians and Patients.

Dream Software Products

Dream Referral – Dream Referral is an e-prescribing, web based software package that walks physician through the process of prescribing medical equipment. Dream Referral indicates to the prescribing physician when any part of the required documentation is not completed or completed incorrectly, ensuring that the patients prescription and associated documentation is completed correctly the first time, thus reducing physicians and HME providers time to finish the documentation. Dream Referral allows complete electronic signature and transmission to the HME provider that will either ship or deliver the required medical equipment. The entire process takes only a few minutes and ensures that the patient receives the necessary equipment much faster than what is currently experienced today. Dream Referral allows for delivery confirmation by the HME provider to ensure that the physician's files are updated with real time information.

Dream Referral goes way beyond the current electronic health records requirements. Dream Referral allows for complete automation, real time reporting, and Fraud Prevention. Dream Referral has the ability to communicate directly with Medicare and Private Insurance systems allowing the required documentation to be delivered to Medicare or the insurance provider well in advance of payment by Medicare or Private Insurance companies. This process could allow Medicare the ability to provide real time

claims adjudication and stop payments to any provider where fraud is believed. In 2010, the OIG estimated that 50.1% of the claims filed for Home Medical Equipment were improperly paid due to the fact that they did not have the required documentation. Dream Referral, when fully integrated could eliminate that entirely. As the system becomes more complex and more data analyzed, it is believed that this system could closely predict Medicare expenditures in the coming years as well as providing real time data analysis rather than years old data analysis. The real time reporting capabilities allow for real time tracking of any events, spikes, irregularities, and any other occurrences in the system.

Dream Referral, once implemented could save providers over \$1.5 billion annually in processing costs related to Medicare Claims. Dream Referral could also dramatically reduce the 15.5% of denied claims by ensuring that orders were completed correctly and accurately and that only those beneficiaries that meet the required criteria would receive reimbursement for the needed equipment.

Summary

In a world where everyone is seeking answers for Healthcare issues, Dream Referral stands ready to solve the largest problem in the industry. Dream Referral is ready to be implemented immediately saving the American Tax payers as much as \$5 billion annually. There is a solution to "Pay and Chase". It is ready today. We just ask your help in ensuring that the problems that have faced the Medicare system for so long do not continue when there is a solution ready to solve the problem.

There has never been a solution that is a win-win for everyone involved

Physicians – Save 65% of employee time spent completing Medicare Paperwork.

Home Medical Equipment Providers – Save over \$1.5 billion annually in processing costs.

Medicare – Elimination of Medicare Fraud.